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# Evaluation of the Social Services and Well-being (Wales) Act 2014 Literature Review

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

This document is also available in Welsh.

This report presents key findings from an extensive review of evidence relating to the principles of the Social Services and Well-being (Wales) Act 2014 which was drawn to inform the development of the evaluation. The findings from the full review can be found in the following technical report: <https://wihsc.southwales.ac.uk/evaluation-implementation-social-services-and-well-being-wales-act-gwerthuso-gweithrediad-deddf-gwasanaethau-cymdeithasol-llesiant-cymru/>

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Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government.

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## **Evaluation of the Social Services and Well-being (Wales) Act 2014: Literature Review**

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## Contents

1.	Introduction.....	2
2.	Method .....	3
3.	Well-being .....	4
4.	Prevention and early intervention .....	7
5.	Co-production .....	10
6.	Multi-agency .....	14
7.	Voice and control.....	16
8.	Financial and economic.....	19
9.	References .....	21

# 1. Introduction

- 1.1 This document is a summary of the extensive review of the literature to inform the evaluation of the *Social Services and Well-being (Wales) Act 2014* (hereafter referred to as 'the Act').<sup>1</sup> The Welsh Government has commissioned a partnership between academics across four universities in Wales and expert advisers to deliver the evaluation. The Act sets out a government vision to produce 'transformative changes' in social service public policy, regulations and delivery arrangements across Wales. It has 11 parts and is informed by five principles that set out a vision to produce transformative changes in public policy, regulations and service delivery. Aligned to it are structures, processes and codes of practice. The Evaluation of the Act – a study called IMPACT – is organised around each of the five principles together with a focus on the financial and economic aspects of the Act's implementation.
- 1.2 The approach to undertaking this evaluation research is to structure the evaluation by using the fundamental principles of the Act as the scaffolding. These principles are:
- Well-being
  - Prevention
  - Co-Production
  - Multi-agency working
  - Voice and control
- 1.3 There is also a focus on the financial and economic considerations of the implementation of the Act and this area constitutes the sixth evaluation study theme.
- 1.4 This approach to the evaluation is complimented with a focus on the following five domains:
- **Individuals** – whether these are people in receipt of support and/or care, or not;
  - **Family and carers** – those people who provide unpaid support to people with needs;
  - **Communities** – place-based communities and other forms of social relationships;
  - **Workers** – whether these are 'frontline' paid care workers, social service and third sector paid workers, team managers or those care managers arranging support and care for others;
  - **Organisations** – whether these are the strategic leaders of public sector bodies like local authorities and health boards (including finance officers), or leaders of key stakeholder organisations.
- 1.5 Each evaluation study theme has a set of research questions. The literature reviews position the evaluation of the Act in the wider academic and policy literature in order to build on the existing knowledge base and debates pertaining to each of the study themes.

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<sup>1</sup> The Technical Report can be accessed from: <https://wihsc.southwales.ac.uk/evaluation-implementation-social-services-and-well-being-wales-act-gwerthuso-gweithrediad-deddf-gwasanaethau-cymdeithasol-llesiant-cymru/>

## **2. Method**

- 2.1 A comprehensive literature search of academic and grey literature was conducted across five of the six themes: prevention and early intervention, co-production, multi-agency working, voice and control, and financial and economic implications.
- 2.2 The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analysis (Moher et al, 2009), informed the action plan/steps for the literature search and review. A combination of search terms agreed and refined by the Evaluation Team individual leads and advisors, were entered into online databases, for example, Scopus, ASSIA, and Social Care Online.
- 2.3 The well-being theme leads used systematic mapping to source relevant literature. A systematic map is a database of academic, grey, and policy literature published on a specified topic that is coded by categories such as subject area, methodology, population of interest or study, and theoretical approach.
- 2.4 The approximate numbers of papers included in the review are as follows:
  - Well-being = 50
  - Voice and Control = 52
  - Prevention = 50
  - Co-production = 52
  - Multi-agency = 48
  - Financial and Economic = 16
- 2.5 The key messages from each of the individual reviews are presented below.

### 3. Well-being

*Pippa Anderson, Jennifer Lyttleton-Smith, Liv Kosnes, Simon Read, Heulwen Blackmore and Zoe Williams*

- 3.1 This review explores the conceptual coherence of well-being as it is applied within the Act and its associated guidance. Well-being is a multi-dimensional construct, often inspiring a selective approach to definition and measurement, and holding the risk of utilisation in nebulous or purely polemical forms. Conceptual coherence in application is therefore crucial to support effective and transparent government policy aims and evaluation. To understand the application of well-being in Wales, we reviewed the current debates around definitions and measurements of well-being as applied to people who need care and support. While we discovered some conceptual coherence around well-being criteria, such as rights and agency, we also found a greater weight allocated to subjective interpretations of well-being and 'happiness' within the literature than is observable within the current Welsh application of the concept. This offers substantial support to the Welsh approach to defining and measuring well-being, while also suggesting a clear path to improvement.
- 3.2 There are two broad conceptual spheres of individual well-being emergent within the literature:
- **Eudemonic Well-being:** Relational and social aspects of well-being, such as access to rights, contribution to society, respect and agency as a citizen, access to positive activities, education and work. Converges with related concepts of 'quality of life' and living standards.
  - **Hedonic Well-being:** Emotional and embodied aspects of well-being, such as pleasure and enjoyment. Converges with mental health concepts of happiness and life satisfaction. This sphere is currently characterized as 'subjective well-being' (i.e. measureable only by an individual's own assessment, rather than by evaluating contributory factors such as physical health or living standards).
- 3.3 The two spheres, while sometimes applied separately, generally complement one another (Henderson and Knight, 2012). For instance, receiving social respect (eudemonic well-being) often leads to personal pleasure (hedonic well-being). Using both perspectives is referred to as the "flourishing" model of well-being by some researchers.
- 3.4 For application of these concepts in policy and measurement, two dominant approaches are defined and evidenced within the literature. Note that each approach may include both eudemonic and hedonic aspects of well-being.
- **The Components Approach:** The components approach is the current dominant discourse for well-being, breaking it down into a series of components or independent elements as commodities for the individual to achieve (Atkinson, 2013). Policies based on this approach seek to enable people to attain these components to enhance their well-being, such as relationships, health, activities of work/leisure, financial stability, and education.
  - **The Capabilities Approach:** This approach claims that well-being can be assessed by understanding individual's capabilities to do or be something and that individuals should be evaluated within the context of available and feasible opportunities, not their achievements (Alkire, 2015; Sen, 2009). The uptake of these opportunities are the essence of 'flourishing lives'.
- 3.5 For each of these approaches, localized domains of well-being relevant to cultural and historical location should be determined and applied to best define and apply the concept in

policy and measurement. These may require personalization to different groups within a population. It has been noted by many that for the purposes of evaluation and monitoring, policy-makers should seek to measure impact of policy (life satisfaction), experience (momentary mood) and eudemonia (purpose).

### **Determining domains of well-being for groups covered by the Act**

- 3.6 Conceptual well-being literature focused directly on people covered by the Act is sparse. The evidence base we found generally focused on whole adult population measurement or was focused specifically on children or older people.
- 3.7 Adult population determinants of well-being reported in the literature include health, personality traits and socio-economic circumstances including financial, income and employment status. For children, it is recognised within recent literature that children's views and experiences – particularly those who are vulnerable - must take precedence in determining their domains of well-being.
- 3.8 Within the UK, four domains central to the well-being of children and young people in care have been identified through such participatory research: relationships; rights; resilience building; and recovery (Selwyn et al, 2017). These sit alongside broad child population indicators of education, protection, and economic stability.
- 3.9 For older people, health, living standards, and agency emerge as the key aspects of well-being within the literature, though there is some critique that measurement of well-being for older people has failed to effectively capture both eudemonic and hedonic spheres, with an excess of focus on the former at population level.

### **The Act and Well-being in Wales**

- 3.10 The Welsh Government definition of well-being within the Act and National Outcomes Framework (NOF) is largely eudemonic, with the hedonic sphere only briefly represented. This is reflected in the Welsh Government approach to well-being measurement, which is identifiable as a components approach with an emphasis on eudemonic determinants of well-being such as housing or employment statistics, rather than hedonic elements such as happiness or emotional state.
- 3.11 While the Well-being Statement and NOF reach towards this by locating attainment as, at least partially determined by an individual's own satisfaction, the boundaries placed around personal well-being outcomes and the measures currently established to evaluate the Act's impact remove the possibility to locate well-being in other spheres of life that it does not cover. The extent, therefore, to which the Welsh approach to well-being, and specifically people who need and receive care and support incorporates subjective, hedonic perceptions, remains debatable.
- 3.12 This review found that inclusion of both eudemonic and hedonic spheres, alongside objective and subjective measures is regarded as important to accurately reflect the potential and actual impact of public policy on the well-being of individuals. In this way, the Welsh Government application of well-being requires further refinement – substantively, a broadening of the degree to which it incorporates subjective hedonic elements and measures, to cohere with the conceptual literature.
- 3.13 In addition, we found greater strength in the arguments presented to support a capabilities approach to measurement, therefore going forward we will consider whether the evidence is strong enough to recommend an adjustment to the current strategy.



## **Next Steps**

- 3.14 The well-being team have explored the conceptual framework of well-being with people in need of care and support, and carers in need of support, from a range of backgrounds and ages. This is allowing us to build on the sparse conceptual literature relating to specific groups and will inform the ongoing refinement of the evaluation strategy.
- 3.15 Having established through the literature review that there is a gap in the meaningful measurement of well-being for people covered by the Act, the team will explore effective and efficient strategies to improve measurement. We will produce recommendations based on practice and policy needs, mindful of the need to minimise the administrative burden on local authorities, balanced with the need to demonstrate the conceptual coherence of well-being in Welsh social care policy.

## 4. Prevention and early intervention

*Fiona Verity, Simon Read and Jonathan Richards*

- 4.1 Preventative approaches to social care incorporate a variety of distinct-yet-related aims informed by assessment and planning processes, co-production and multi-sector working. In this sense, many of the themes reported elsewhere in the Review notably overlap with the design and delivery of preventative services.
- 4.2 Alongside understanding the results and impact of preventative work in social care, the broader focus of this review of the literature is to explore the preventative frameworks being deployed, how the underlying concepts are understood and the manner in which interventions are implemented and evaluated. This is done through four sections:
- concepts and definitions in prevention and early intervention;
  - contemporary drivers for the preventative focus in social care;
  - state of the evidence about prevention in social care; and
  - prevention approaches in social care.

### **Concepts and definitions in prevention and early intervention**

- 4.3 Social care literature on prevention and early intervention more typically identifies a three-tiered framework consistent with a public health paradigm (Gough, 2013; Miller and Whitehead, 2015). These three levels are:
- tertiary / downstream – where interventions target urgent, existing issues;
  - secondary / midstream – targeting identified problems and preventing escalation; and
  - primary / upstream – targeting entire populations with support before problems set in.
- 4.4 Each stratum requires the provision of different initiatives aimed at differing audiences. Some authors (e.g. Warin, et al, 2015) view these strata in terms of temporality, suggesting preventative agendas divorced from everyday reality may be less effective than those grounded in lived experiences.
- 4.5 While there is broad agreement on the three-tiered framework, there remains considerable variation in how the term ‘prevention’ itself is used (Curry, 2006; Marczak et al, 2019). Terminology overlaps and disparities are reportedly common, encompassing a diverse range of activities and interventions (Allen and Glasby, 2010; Marczak et al, 2019). Within this loose application of prevention concepts, there is a general view that social care has predominantly focussed on tertiary and secondary approaches rather than primary, upstream work (Gough, 2013).
- 4.6 There are growing calls for the varying levels of a three-tiered framework to be implemented more collectively than independently, and a more nuanced social care preventative framework (Marczak et al, 2019).

### **Contemporary drivers for the preventative focus in social care**

- 4.7 As with its historical development, contemporary strides towards prevention have parallel and sometimes conflicting drivers (Gough, 2013; Clark, 2019; Marczak et al, 2019). Alongside economical, cost-saving imperatives, prevention is widely conveyed in policy discourse to reduce service demand, as well as a means of enacting social justice and inequality reduction. These various focal points have implications for the interventions that are considered for commissioning, planning and decision-making.

- 4.8 Authors have highlighted the need for ‘interdisciplinary, interagency, and interdepartmental’ local commissioning frameworks more aligned to community-specific needs (Kerslake, 2011; 16). The discursive emphasis on prevention as a cost-saving exercise has also drawn critique. While community energy and resources are largely regarded as untapped, there are concerns that top-down approaches are less effective in harnessing these than smaller-scale, bottom-up, community-led projects.
- 4.9 Recent developments with community businesses, social enterprises and cooperatives have offered a burgeoning evidence base comprising measurable cost-saving benefits alongside indicators of community strengthening and development (Hull et al, 2016; Bedford & Harper, 2018).

### **State of the evidence about prevention in social care**

- 4.10 The scientific evidence base on social care prevention is perceived to be limited. This is attributable to a ‘paucity of longitudinal studies’ (Curry, 2006; 1) that track implementations of preventative programmes over time (Marczak et al, 2019). This limitation arguably complicates the positive value that such approaches are anecdotally felt to offer.
- 4.11 However, recent efforts to contextualise prevention work outcomes through cost benefit analysis have indicated that there is potential for evaluations that may aid understanding of their economic impact (Knapp, et al, 2013).
- 4.12 Beyond this, the viewpoint of an ‘evidence deficit’ has been increasingly unpicked. Assessing prevention requires a long-term perspective and consistent interventions. Yet, the social conditions that preventative measures aim to change are complex and dynamic. Furthermore, the diverse remit of prevention work means that methods for assessment may vary dramatically. There is a considerable evidence base around the lived experience of social services users and practitioners, and from community developers, which is often disregarded relative to empirical studies, as well as potential to better use routinely collected data to understand effectiveness of initiatives (e.g. Emerson et al, 2011; Shapiro et al, 2013).

### **Prevention approaches in social care**

- 4.13 Prevention approaches in social care mirror the framework outlined above, with a predominant focus on secondary and tertiary interventions. One overriding emphasis is the need to identify and respond to individual needs through re-enablement programmes, information provision and self-directed support (Allen and Glasby, 2010). These are generally entwined with aims to maintain independence and social connectedness. Another focus has been on community development, particularly with recent growth in community businesses and social enterprise research (Abrams et al, 2019; Bedford and Harper, 2018; Hull et al, 2018). Many of these initiatives adopt a ‘strengths perspective’ and use ideas of social capital and asset-based community development (ABCD) while also being principled in terms of community control and co-production. Consequently, in the context of contemporary drivers, numerous authors are contributing to the evidence base about most appropriate means to encourage participation, highlighting the importance of sensitivity to diverse local contexts and the need for further commissioning support in order to aid ongoing evaluation of the process, impact and outcomes of such work.

### **Literature review themes**

- Definitions of prevention in social care are contested with a range of approaches that span the individual, community, and wider social structures.

- Prevention is inextricably linked to co-production, voice and control and multiagency working.
- Prevention in social care can be implemented for many reasons. These relate to the fulfilment of social justice principles and/or a view that prevention is a way to save money and slow demand for services. Some argue prevention is not a cost neutral activity but requires long-term investment.
- There is a need for stronger commissioning frameworks that support evidence-based decisions about where resources should be allocated for preventative purposes.
- There are a range of sources of evidence for the effectiveness, and impact of preventative social care (lived experience, practitioner wisdom, and scientific evidence). However, the scientific evidence base for prevention in social care is 'underdeveloped', and where there is evidence, it can be underused in practice.
- Recent work in the field of community businesses, social enterprises and cooperatives offers potential solutions to measures of impact and effectiveness in relation to specific local community needs.

## 5. Co-production

*Nick Andrews, Gideon Calder, Noreen Blanluet, Sion Tetlow and Sarah Wallace*

- 5.1 This summary of literature reviewed on the theme of co-production is divided into three sections. In the first, we summarise key aspects of the changes required in the successful promotion of co-production in social services. In the second, we identify lessons for policy in Wales, gleaned from evidence around the implementation of co-production in different countries and settings. In the third, we highlight key enabling factors, relevant to the practical achievement of co-production in the sectors addressed by the Act.

### **Organisational strategy**

- 5.2 Organisational structures and strategy was highlighted within the literature as being key in co-production. Changes in organisational strategy which will enable successful co-production have been highlighted below, structured around key issues to be tackled, key changes required, and key aspects of learning needed to facilitate change.

### 5.3 *Key issues that need to be tackled*

- Potential incompatibilities between co-production, and dominant managerial approaches (Parry-Jones & Soulsby 2001; Keinhans 2017)
- What makes co-productive projects sustainable (Denbighshire Voluntary Services Council (DVSC) 2018; Meerkerk 2018)
- Power-sharing in sensitive services, e.g. those where safeguarding duties are paramount. (Munroe 2011; Clarke et al. 2011)
- Tensions are to be found between:
  - policy imperatives and organisational/workplace constraints (Gunasakera et al. 2017; Pearson et al. 2017; Pilgrim 2018; Thom & Burnside 2018)
  - co-production of relevant knowledge about particular services and established requirements of research funders and organisations (Allen et al. 2018; Baines 2018; Pilgrim 2018)
  - service user and provider perspectives on appropriate services (McCarry et al. 2018; Wharne 2015)
  - service-centred and wider social imperatives (Vaeggemose et al. 2017)
- Gauging the savings and costs involved in co-production, and the value added (Bovaird & Loeffler 2012; Harlock 2014)

### 5.4 *Key changes that are required*

- ‘Culture change’ in order to allow for genuine co-production (Bradley 2015; Patterson et al. 2011)
- Adaptation to legacies of spending cuts affecting services (Keinhans 2017; Pearson et al. 2017; Milson 2018)
- New forms of public management conducive to co-production (Keinhans 2017)
- Revision of priorities of services historically run on separate, non-co-productive lines (Gunasakera et al. 2017)
- Forms of language which translate across different professional and service-user perspectives (Patterson et al. 2011)

### 5.5 *Key aspects of learning to facilitate change*

- Better use of evidence in service development (Andrews et al. 2015)

- Integrated, pluralistic and hybrid approaches to relations between stakeholders (Schlappa & Imani 2012; Nandram & Koster 2014; O’Leary et al. 2012)
- Acknowledgement of stages of development of co-produced services (Freeman et al. 2016)
- Insights from the full range of academic disciplines (Ellis 2017; Allen et al. 2018)
- Incorporating professional and non-professional insights (Vaeggemose et al. 2017)

## **Participation**

5.6 The literature also presented some key findings relating to participation and what issues, changes and enablers were identified relating to co-production.

### **5.7 *Key issues that need to be tackled***

- Different barriers to participation facing different groups (Beresford 2013; Cree et al 2015)
- Historic lack of consultation with certain groups (Bradley 2015)
- Risks around over-protective practice undermining agency of service-users (Sanders 2006; Smale et al. 1993)
- Barriers to participation posed by factors beyond a service’s control (Doran & Buffel 2018)
- Risks around overlooking some forms of organisation (DVSC 2018)

### **5.8 *Key changes that are required***

- Finding workable approaches which genuinely accommodate all parties (Andrews et al. 2009; Smale et al. 1993)
- Recognition of specific expertise embodied in local practice (DVSC 2018)
- Development of supporting infrastructure to enable participation by all groups (Milson 2018)
- Finding ways of working with or around risk-/deficit- based practices (Gale et al. 2018)
- Reform of potentially exclusionary aspects of organisations’ established working cultures (Andrews et al. 2015)

### **5.9 *Key aspects of learning to facilitate change***

- Promoting democratic processes in negotiating relationships (Budge et al. 2018)
- The role of relationship-centred and person-centred approaches (Andrews et al 2009; Andrews et al. 2015; O’Leary 2012; Nandram & Koster 2014; Maurits et al 2018)
- The role of social capital (Meerkerk 2018)
- The different roles and impacts of co-produced services for different groups (Ford 2015)
- New/adapted forms of assessment (Miller & Barrie 2016; Andrews 2009)

## **Lessons for Welsh policy**

5.10 From comparative evidence, we can identify clear value in:

- The Act’s pluralistic specification of the key features of co-production, echoing policy in Norway (Askheim et al. (2016)

- Prioritising learning from existing projects using co-production (Lowe & Plummer 2019)
- Focusing on what matters to people at 'ground level' (Miller & Barrie 2016; Weaver 2018; Vrangbaek et al. 2019)
- Being realistic about what is required by way of support and incentives to achieve the Act's stated aim of 'building the local economy of people exchanging their skills, interests and time' (Voorberg et al. 2018)
- Accepting and working with the expectation that service transformation will be – 'multi-layered, messy, fluid and emergent' (Dougall et al. 2018)

5.11 Alongside this, there are clear challenges in:

- Achieving the 'culture change' required to enact genuine co-production (Miller and Barrie)
- Bridging the gulf between different scales of co-production relevant to the provision of care and support (Bovaird et al. 2014)
- Genuine involvement of specific groups in the design and management of services (Duner et al. 2019)
- Avoiding any impression that co-production has been promised but not realised (Flinders & Wood 2018)

### **Enabling factors**

5.12 The enabling factors identified below are conclusions drawn from an overview of points emerging from across all literature reviewed.

5.13 *Knowledge, understanding and planning*

- Thinking wide to gain a clear understanding of the potential for co-production across the design, delivery and evaluation of public services;
- Ensuring clarity on the distinction between co-production as such, and related ways of working such as collaboration; and
- Importance of combining different kinds of evidence in evaluating co-productive projects.

5.14 *Recognising and responding to challenges*

- Recognising and grappling with the challenges for co-production within the complex multi-level governance of public services;
- Recognising and addressing the tension between the discourses of individual rights/consumerism and mutuality/compromise;
- Challenging existing approaches to planning and performance that call for predictability and control and thus allowing for emergence; and
- Willingness to confront what's at stake when co-production does *not* work in the expected ways, and considering the implications of this for future practice.

5.15 *Fostering a supportive and enabling culture and environment*

- Developing a culture and way of thinking in professionals and organisations that truly values the worth and knowledge individuals and communities;
- Providing supportive environments and embedded systems that enable co-production, which come at cost;
- Developing a common language and meaningful relationships through caring dialogue and deliberation, which creates trust;

- Overcoming risk aversion in decision making in the face of hostile media coverage and litigation;
- Leadership that devolves power and promotes agency at the frontline;
- Listening to, and amplifying seldom-heard voices; and
- A greater focus on the outcomes of co-production.



## 6. Multi-agency

*Carolyn Wallace, Alison Orrell, Tony Garthwaite, Sion Tetlow and Sarah Wallace*

- 6.1 Working together across agencies is challenging but it provides opportunity to problem solve and address the fragmentation of service delivery aggravated by organisational autonomy, competition and choice (Kings Fund, 2019, 2013; Leichsenring et al., 2016). It achieves this by sharing each other's knowledge and skills, coming to some mutual understanding through providing time and space for people to come together thereby benefitting individuals, families and communities, but not necessarily health or social care organisation economics (Fernandez et al, 2018) and are dependent on many variables.
- 6.2 In recent years the focus of how we work together has been moving away from its main concern regarding health and disease (NHS specifically) to an understanding that health and wellbeing have multiple determinants and that working together should be people centric through empowering people and their communities to work with professionals, organisations and policy makers in order to ensure that people receive 'the right care, at the right time, in the right place, in accordance with their needs and local context' (WHO, 2018).
- 6.3 The Act itself uses words such as 'cooperation', 'integration of care', 'partnership', 'joint arrangements' to describe its expectation as to how we should work together. Regulations such as 'The Care and Support Partnership Arrangements for Population Assessments (Wales) Regulations 2015' and 'The Partnership Arrangements (Wales) Regulations 2015' specify terms such as 'partnership' which include specified functions and arrangements such as partnership boards, sharing information, pooled budgets and referral procedures.
- 6.4 The term 'multi-agency' in the literature is often used interchangeably with inter-agency (between agencies) and partnership working. Peckover and Golding (2017) have acknowledged this multi-level approach in their definition and we are using it for this literature review:
- 'Multiagency working includes work undertaken by different professionals with the same client and/or family, often requiring information sharing, coordination of service provision and joint visiting and/or assessment. Another context is the formal strategic arrangements between local partner agencies' (Peckover & Golding, 2017: 41).*
- 6.5 In this chapter we first of all offer an understanding of the many definitions of the terms used in the Act to describe how we work together. We attempt to show the relationship between them (through their characteristics) and how multi-agency working fits in the continuum between parallel working and integration.
- 6.6 To do this, we acknowledge that a complex world of working together is developed through the interaction of relationships where the individual service user (local level) influences the context of the family, carer which in turn influences knowledge and change in care organisations (Cilliers, 1998; Preiser, 2016).
- 6.7 Considering the complexity of the whole system helps us to consider these domains whilst also identifying and understanding the success factors and challenges, mechanisms and processes required to work together to meet the aims of the Act.
- 6.8 Key messages from this literature review are:
- Terms are often used interchangeably but have common characteristics and success factors.
  - Building equal relationships with common language and purpose, culture (trust, honesty, reciprocity), managing expectations, permissions and processes are key although can be resource (including time) intensive.

- Working together across agencies is challenging but it provides opportunity to problem solve by sharing each other's knowledge and skills, so benefitting individuals, families and communities.
- There is a gap in the multiagency literature on the views and experiences of the individual, but especially family and carers and the workforce as the literature focusses mainly on care organisations, policy and governance.
- Integrated care has mainly focussed on health service delivery until recent years where it is now moving towards health and social care integration.
- Not one study has sought to identify the success factors of a country's workforce working towards multiagency working.

## 7. Voice and control

*Mark Llewellyn, Roiyah Saltus, Heulwen Blackmore, Sion Tetlow, Zoe Williams and Sarah Wallace*

7.1 In respect of the concept of ‘voice’ and ‘control’, the Act provides no formal definition. There are fragments of definitions within different Parts of the Act, and the Codes of Practice. For example, Part 6 of the Act provides a number of key statements which are useful proxies to be considered in lieu of formal definitions, and in addition, the Code of Practice for Part 2 draws from the National Outcomes Framework in identifying key aspects of what it means to exercise ‘voice’ and ‘control’:

- *A right to be heard as an individual...to have control over their daily lives*
- *My voice is heard and listened to*
- *I speak for myself and contribute to and contribute to the decisions that affect my life or have someone who can do it for me.*

7.2 Our working definition of voice and control is therefore based on having one’s voice heard and listened to as a basic right, having control over daily life by contributing to decisions and, if needed, receiving support to be heard.

7.3 Perhaps tellingly, on the whole, the published literature also does not provide clear definitions of the terms ‘voice’ and ‘control’ (Vamstad 2016; Bamford and Bruce, Quereshi et al, Gabriel and Bowling, Quereshi and Henwood, all cited by Callaghan et al 2014). What the literature reveals is the fact that terms such as voice and control are defined in various ways, with proxy terms often used interchangeably leading to conceptual overlap.

7.4 While most of the literature available does not explicitly use or define the terms ‘voice’ or ‘control’, a number of similar or related concepts have been defined within the literature e.g. person-centred care (Washburn and Grossman 2017), empowerment (Keyes et al 2015), participation (Havlicek et al 2018), self-determination (Eades 2018), personalisation (Department of Health 2015; Glenndinning et al 2015) and shared decision-making (Brogan et al 2018).

7.5 The review of the literature around voice and control can be understood under the following broad categories.

### **Individuals**

7.6 The review explores how drives to increase voice and control manifest and impact on the lives of individuals, with a focus on those requiring support and care provision. The findings covered a range of population groups, with literature revealing the context of particular groupings including social care setting, for example where older people had more/less voice and control (Callaghan et al 2014; Vamstad 2016; Darby et al 2017; Dunér et al 2019).

7.7 Issues like quality of life (Reindl et al 2016; Morris et al 2017), self-advocacy (Tideman and Svensson 2015; Hamilton et al 2017), and the voice of people with intellectual disabilities was captured.

7.8 The findings in this section include:

- the complexity of implementing voice and control principles across different care settings;

- the importance of advocacy and self-advocacy in creating a sense of voice and control for service users;
- the challenges in sharing control across the organisation and service user in different social care settings; and
- the challenges involved in implementing voice and control principles with different service user demographics.

## **Carers**

- 7.9 This centred on the issues in the literature around how voice and control is enhanced or diminished for carers (Rand and Malley 2014; Glenndinning et al 2015; McNeilly et al 2018; Watts and Cavaye 2018). Given the focus of this in the Act, the challenges of assessment tools and processes (Seddon and Robinson 2015; Ewing et al 2016) and of resources and budgets (Glendinning et al 2015; Larkin 2015; Galiatsatos et al 2017; Singleton and Fry 2019) are positioned as key factors shaping how the voice and control of carers may be enhanced or limited.
- 7.10 The key messages from this section of the literature review are:
- the need to find the appropriate balance between notions of citizenship and having greater financial control;
  - the challenges of having control over finances in giving carers and cared-for individuals voice and control; and
  - the importance of quality social care practice in empowering carers to gain a sense of voice and control.

## **Workforce**

- 7.11 The review also examined voice and control and the workforce across social care settings. It explored policy and practice in supporting staff, barriers and enablers in fostering empowerment, and shared control and decision making (Gridely et al 2014; Keyes et al 2015; McCarter et al 2016; Brogan 2018), in both the development the person-centred care (Gridley et al 2014; Hanga et al 2017; Washburn and Grossman 2017; Dunér et al 2019) and advocacy (Eades 2018).
- 7.12 The key messages that came from this section are:
- the importance of person-centred approaches in fostering voice and control principles for service users;
  - the challenges inherent in implementing policy informed by voice and control principles; and
  - the importance of the relationship between practitioner and service user in creating a good sense of voice and control for service users.

## **Organisations**

- 7.13 The final section of the review focused on the role of care and health organisations and voice and control. The literature focuses on one key area, assessment, and the ways in which assessment of care (Darby et al 2017; Hanga et al 2017) and self-assessment (Keyes et al 2015), and approaches to the assessment process (Skills for Care 2018), impacts voice and control principles and practices for care organisations (Seddon and Robinson 2015; Tucker et al 2018).

7.14 The key findings were that:

- there are challenges in instilling voice and control principles in health and social care assessments; and
- person centred practice and conversational approaches can provide a good platform for voice and control principles to be implemented in social care.

### **Enablers and barriers**

7.15 Overall, the voice and control literature review highlighted a number of barriers and enablers that can hinder or assist individuals who are receiving care and support to have greater input into their care (voice) and a greater say over what happens (control).

#### **7.16 *Enablers***

- Advocacy and self-advocacy in creating a sense of voice and control for service users;
- Quality social care practice is giving carers a sense of voice and control;
- Person-centred approaches in fostering voice and control principles for service users;
- Relationships between practitioner and service user in creating conditions for voice and control to be effective;
- Person-centred and conversational approaches to social care practice.

#### **7.17 *Barriers***

- Lack of clear definition in the literature as to what voice and control means;
- Complexity of applying voice and control principles in different social care settings;
- Sharing control between the organisation and service user in different social care settings;
- Complexity of implementing voice and control principles with different service user groups, e.g. older people with dementia, or young children.

## **8. Financial and economic**

8.1 This section of the literature review has considered the economic implications of specific interventions across a variety of social care settings, as well as the range of models employed to assess the costs incurred and benefits generated in different social and health care contexts.

8.2 Some of the key messages are organised into three main sections:

- Methodological issues when considering the financial and economic implications of policy
- Economic and financial analysis of interventions versus usual care
- Exploring strategies for reducing government social care spending

### **Methodological issues when considering the financial and economic implications of policy**

8.3 This section explores literature around methodological issues that occur when considering the financial and economic implications of policy.

Key messages:

- The difficulties of measuring improvements in well-being, in an objective manner, although a number of approaches are available (Frick and Kunz, 2008);
- The complexity of assessing 'cost-effectiveness' of health and social care services in conjunction with quality of life indicators (Frick and Kunz 2008; Teresi et al, 2017);
- The difficulties of attributing improvements in well-being to the direct impact of the SSWBA, as opposed to other factors;
- Little is known about measuring improvements in use of resources as a consequence of integrated care, partly due to the fact that adequate methods are lacking, partly due to a failure to include economic evaluation in the design, planning and implementation of integrated care (Stein et al, 2016);
- The availability and challenges of using different tools and models to evaluate the economic health of specific services (Sanders et al, 2017);
- For modelling tools interventions to be successful, they should be co-produced by designers of the intervention and the users themselves (Sanders et al, 2017);
- To help capture all the costs and benefits relevant to the assessment of public health interventions, Marsh et al (2012) propose 1) the trend of modelling approaches that better capture the effects of public health interventions needs to continue with economists considering a broader range of modelling techniques, facilitated by better data on behavioural outcomes 2) the use of 'valuation paradigms' which include the capabilities approach and the subjective well-being approach.

### **Economic and financial analysis of interventions versus usual care**

8.4 This section explores literature comparing economic and financial analysis of specific interventions versus usual care.

Key messages:

- Specific interventions can have positive impacts on outcomes and cost-effectiveness for social care organisations, for example, Bauer (2016);

- Certain interventions may be more expensive in the short term, but may offset further costs downstream in the longer term (see PBCM intervention) (Rutter and Quinton, 1984);
- Caution should be applied to the use of interventions that have limited amounts of research and evaluation literature supporting their use.

### **Exploring strategies for reducing Government social care spending**

8.5 This section explores strategies for increasing capacity over a variety of social and health care settings.

Key messages:

- Challenges and complexities of using 'cost-effectiveness' models in different social and health care contexts (Edwards et al. 2014);
- Long term, preventative strategies may increase capacity (Byrne-Maguire, 2017);
- Improving the problem of social isolation amongst older patients, and undertaking an annual dementia review for dementia patients could have the potential to reduce delays in hospital discharge (Landeiro et al, 2015; Goddard et al, 2016)
- There is much debate about the difference in resource implications of co or multi-morbidity compared to just a single morbidity (Brilleman et al. 2013);
- The distribution of costs and benefits associated with the SSWBA may not be distributed evenly over different parts of Welsh society (age, sex, location etc.).

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